Note: These addenda will not appear in the Code of Federal Regulations.

Addendum A -- Explanation and Use of Addendum B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2001. Addendum B contains the RVUs for work, non-facility practice expense, facility practice expense, and malpractice expense, and other information for all services included in the physician fee schedule.

Addendum B--2001 Relative Value Units and Related Information Used in Determining Medicare Payments for 2001

This addendum contains the following information for each CPT code and alphanumeric HCPCS code, except for alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics), and codes for anesthesiology.

1. CPT/HCPCS code. This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. Modifier. A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier -26) for the service. If there is a PC and a TC for

the service, Addendum B contains three entries for the code: One for the global values (both professional and technical); one for modifier -26 (PC); and one for modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier -53 is shown for a discontinued procedure. There will be RVUs for the code (CPT code 45378) with this modifier.

3. Status indicator. This indicator shows whether the CPT/HCPCS code is in the physician fee schedule and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the fee schedule if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national decision regarding the coverage of the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.)

C = Carrier-priced code. Carriers will establish RVUs and payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report.

D = Deleted code. These codes are deleted effective with the beginning of the calendar year.

E = Excluded from physician fee schedule by regulation. These codes are for items or services that we chose to exclude from the physician fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the physician fee schedule for these codes. Payment for them, if they are covered, continues under reasonable charge or other payment procedures.

G = Code not valid for Medicare purposes. Medicare does not recognize codes assigned this status. Medicare uses another code for reporting of, and payment for, these services.

N = Noncovered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

P = Bundled or excluded code. There are no RVUs for these services. No separate payment should be made for them under the physician fee schedule.

-- If the item or service is covered as incident to a physician's service and is furnished on the same day as a physician's service, payment for it is bundled into the

payment for the physician's service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician's service).

-- If the item or service is covered as other than incident to a physician's service, it is excluded from the physician fee schedule (for example, colostomy supplies) and is paid under the other payment provisions of the Act.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = Injections. There are RVUs for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Exclusion by law. These codes represent an item or service that is not within the definition of "physicians' services" for physician fee schedule payment purposes. No RVUs are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. Description of code. This is an abbreviated version of

the narrative description of the code.

5. Physician work RVUs. These are the RVUs for the physician work for this service in 2001. Codes that are not used for Medicare payment are identified with a "+."

6. Fully implemented non-facility practice expense RVUs. These are the fully implemented resource-based practice expense RVUs for non-facility settings.

7. Year 2001 Transition non-facility practice expense RVUs. Blended non-facility practice expense RVUs for use in 2001.

8. Fully implemented facility practice expense RVUs. These are the fully implemented resource-based practice expense RVUs for facility settings.

9. Year 2001 transition facility practice expense RVUs. Blended facility practice expense RVUs for use in 2001.

10. Malpractice expense RVUs. These are the RVUs for the malpractice expense for the service for 2001.

11. Fully implemented non-facility total. This is the sum of the work, fully implemented non-facility practice expense, and malpractice expense RVUs.

12. Year 2001 transition non-facility total. This is the sum of the work, transition non-facility practice expense, and malpractice expense RVUs for use in 2001.

13. Fully implemented facility total. This is the sum of

the work, fully implemented facility practice expense, and malpractice expense RVUs.

14. Year 2001 transition facility total. This is the sum of the work, transition facility practice expense, and malpractice expense RVUs for use in 2001.

15. Global period. This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = The code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = The code is part of another service and falls within the global period for the other service.

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